



Promethean
Human Designs Ltd



Training & Education Syllabus

PATIENT SAFETY AND PSIRF TRAINING SYLLABUS

Human Factors, Learning Response, Investigation and
Improvement Programmes for NHS and Non-NHS
Organisations

Introduction

We provide practical, evidence-informed training for organisations seeking to strengthen patient safety capability, embed Human Factors and systems thinking, and deliver high-quality learning responses in line with the Patient Safety Incident Response Framework (PSIRF). These programmes are designed to support safer care by improving how organisations understand risk, learn from patient safety events, engage with staff and families, and translate insight into meaningful improvement. Our training is suitable for a wide range of healthcare audiences, from teams new to Human Factors and PSIRF through to experienced staff leading investigations, thematic reviews, and safety improvement work. Courses can be delivered as stand-alone sessions or combined into a structured development pathway to build capability across patient safety, governance, quality improvement, and operational leadership functions.

Suggested Learning Pathway

To support commissioning and workforce development, the programmes can be positioned as a progressive pathway from foundation learning through to advanced investigation and specialist analysis.

Level	Programmes
Foundation	Introduction to Human Factors PSIRF Fundamentals
Practitioner	PSIRF: Systems Approach to Learning from Patient Safety Events Compassionate Engagement with Patients, Families and Staff
Specialist	Creating Outcomes: Action Design and Implementation Masterclass Thematic Analysis for Patient Safety Learning PSIRF Oversight Training (Leadership)
Advanced	PSIRF Investigation Masterclass

1) Introduction to Human Factors

Foundation course for staff who are new to Human Factors, systems thinking, and patient safety improvement.

Purpose: This practical introductory session provides a clear and accessible grounding in Human Factors and Ergonomics. It helps participants understand why people do what they do at work, why systems can still fail even when staff are committed and capable, and how safer systems can be designed to support good performance. The session introduces key ideas in human performance, error, bias, teamwork, culture, and design, creating a strong foundation for patient safety, quality, reliability, and improvement work.

Why this course matters to organisations

This course helps teams build a shared language for discussing safety, performance, and risk. It supports a shift away from over-reliance on individual vigilance and towards practical thinking about systems, conditions, and design. It is particularly useful for organisations seeking a foundation that can underpin wider PSIRF, improvement, governance, and safety training.

Intended audience

Suitable for staff and teams who want a clear introduction to Human Factors, with no prior knowledge required. It works well for mixed groups, including frontline staff, supervisors, team leaders, managers, improvement leads, and staff working in safety, quality, or risk roles.

Topics covered

- Historical events and case examples that illustrate the importance of Human Factors
- Systems approaches to safety, including Safety-I and Safety-II
- Types of error and why they occur
- Performance-influencing factors in everyday work
- Cognition, heuristics, and decision-making
- Just culture, learning culture, reporting culture, and authority gradients
- Group decision-making and the value of collective insight
- Hierarchy of controls and designing work for success rather than relying on perfect performance

Learning outcomes

By the end of the course, participants will be able to:

- Explain core Human Factors concepts in plain language and describe why they matter for safety and performance
- Identify common factors that influence performance in their own work setting
- Recognise how error, bias, and decision-making shape outcomes
- Use a simple systems lens to discuss incidents and everyday work
- Describe practical design and control options that improve the likelihood of safer, more reliable care

Format and duration

- Duration: 1 day / 6 hours
- Delivery: Face-to-face or live online, using short exercises, facilitated discussion, and case studies
- CPD: Equivalent to 6 CPD points.

Tailoring and follow-up

For in-house delivery, examples and discussion can be tailored to the organisation's clinical context, service pressures, and improvement priorities. Participants receive a certificate of completion and are offered a 30-minute post-session support call for advice on applying Human Factors in practice.

2) PSIRF Fundamentals

Introductory PSIRF course for multidisciplinary staff who need to understand the framework and contribute well to learning responses.

Purpose: This practical one-day course introduces the Patient Safety Incident Response Framework (PSIRF) and what it means for day-to-day practice in organisations. It helps participants understand the principles behind PSIRF, the move from investigation and blame towards proportionate systems-based learning, and the role of just and restorative approaches in responding to patient safety events. Participants also explore key learning methods such as swarms and After Action Reviews (AARs), with a focus on turning insight into meaningful improvement.

Why this course matters to organisations

This course supports local PSIRF implementation by giving staff a clear understanding of what good incident response looks like in practice. It helps organisations develop more consistent, learning-focused approaches to patient safety events, improve staff confidence in PSIRF processes, and strengthen links between learning, staff support, and improvement.

Intended audience

Suitable for clinical and non-clinical staff who are involved in patient safety learning and improvement. It works well for multidisciplinary groups including ward and service teams, matrons, charge nurses, clinical leaders, patient safety specialists, governance and risk teams, quality improvement leads, and staff who contribute to or facilitate learning responses under PSIRF.

Topics covered

- Overview of PSIRF, including its principles and what good practice looks like
- Proportionate learning responses in healthcare settings
- Systems thinking for patient safety, including Safety-I and Safety-II
- Just culture and learning culture
- Restorative approaches and support for staff following harm
- Practical learning methods, including swarms and After Action Reviews
- Turning learning into action using the hierarchy of controls

Learning outcomes

By the end of the course, participants will be able to:

- Describe the purpose and core principles of PSIRF
- Explain what PSIRF means for responding to patient safety incidents
- Use a systems lens to explore what happened and why, focusing on learning rather than blame
- Apply practical learning methods such as swarms and AARs
- Understand the basics of just and restorative approaches
- Contribute to the design of stronger, more proportionate improvement actions

Format and duration

- Duration: 1 day / 6 hours
- Delivery: Face-to-face or live online workshop with short exercises and case studies
- CPD: Equivalent to 6 CPD points.

Tailoring and follow-up

Training can be tailored to local governance arrangements, service context, and the organisation's stage of PSIRF implementation. Participants receive a certificate of completion and are offered a 30-minute post-session support call.

3) PSIRF: Systems Approach to Learning from Patient Safety Events



Practitioner course for staff who lead or support PSIRF learning responses and need practical tools, structure, and confidence.

Purpose: This practical two-day course develops the knowledge and skills needed to plan and facilitate PSIRF-aligned learning responses to patient safety incidents. It focuses on how to scope and structure proportionate responses, gather and synthesise information, apply Human Factors and systems thinking, and produce clear outputs that support learning and improvement. Participants practise learning response methods and build confidence in engaging compassionately and effectively with staff, patients, carers, and families.

Why this course matters to organisations

This course helps build practitioner capability for those responsible for leading or supporting learning responses. It strengthens the consistency and quality of incident response practice, improves the quality of outputs and actions, and supports a more confident and proportionate organisational approach to PSIRF.

Intended audience

Designed for practitioners who will lead or support learning responses under PSIRF, including patient safety specialists, governance and risk leads, quality improvement leads, senior nurses, clinical leaders, and operational managers. The course is suitable for clinical and non-clinical staff and works best for participants who already have a basic grounding in Human Factors and systems thinking.

Topics covered

- Human Factors and systems thinking for incident response
- Work as done, Safety-II, and drift to failure
- The NHS patient safety landscape and the place of PSIRF within it
- PSIRF tools and documentation for scoping and planning responses
- Systems tools for learning, including SEIPS and timeline mapping
- Learning response methods, including swarms and After Action Reviews
- Information gathering, interviewing skills, and multidisciplinary approaches
- Involving patients, carers, and families, including Duty of Candour
- Writing clear, decision-useful outputs
- Additional analytical methods, including task analysis and human reliability analysis
- Just culture, psychological safety, and authority gradients

Learning outcomes

By the end of the course, participants will be able to:

- Lead PSIRF-aligned learning responses using proportionate approaches
- Apply Human Factors and systems thinking to understand how system conditions shape risk
- Use PSIRF documentation and methods to plan, scope, and structure a response
- Facilitate swarms and AARs effectively
- Use systems tools to develop a coherent account of what happened and why
- Gather stronger evidence through effective engagement and interviewing
- Involve patients and families appropriately and compassionately
- Produce clearer, more useful outputs that support improvement
- Promote a just, learning-focused culture during and after patient safety events

Format and duration

- Duration: 2 days / 12 hours
- Delivery: Face-to-face or live online workshop with practical exercises and case studies
- CPD: Equivalent to 12 CPD points.

Tailoring and follow-up

Examples and activities can be adapted to the organisation's incident profile, governance arrangements, and priority safety themes. Participants receive a certificate of completion and are offered a 30-minute post-course support call.

4) Creating Outcomes: Action Design and Implementation Masterclass



Specialist course focused on developing stronger safety actions and translating learning into measurable improvement. responses.

Purpose: This course supports staff involved in PSIRF implementation, learning responses, safety action development, and quality improvement by providing a deeper understanding of how different actions address different contributory factors, task demands, and system conditions. It is designed to help organisations move beyond weak or superficial recommendations and develop safety actions that are more robust, realistic, and sustainable. The course is relevant to both reactive learning after incidents and proactive improvement work such as service redesign, pathway change, or risk reduction activity.

Why this course matters to organisations

Many organisations are confident in identifying learning but less confident in translating that learning into strong actions. This course helps improve the quality of action plans, supports more effective oversight and governance, and strengthens the link between investigation outputs, improvement planning, and sustainable change.

Intended audience

Suitable for clinical and non-clinical staff involved in patient safety, governance, quality improvement, incident response, service redesign, or operational leadership. This includes clinicians, managers, patient safety specialists, governance leads, and quality leads. It is helpful, though not essential, for participants to have completed introductory Human Factors or PSIRF training beforehand.

Topics covered

- Task analysis
- Human reliability analysis and error classification
- Hierarchy of controls
- Action evaluation and review
- Designing stronger versus weaker actions
- Anticipating implementation challenges and unintended consequences
- Linking safety actions to improvement planning and service change

Learning outcomes

By the end of the course, participants will be able to:

- Apply human reliability concepts to understand work as done and identify meaningful intervention points
- Select and design stronger safety actions using the hierarchy of controls
- Evaluate proposed actions for likely effectiveness, feasibility, sustainability, and unintended consequences
- Translate learning from incidents, risks, and near misses into practical quality improvement actions
- Contribute more confidently to action planning, governance discussions, and PSIRF learning responses

Format and duration

- Available as a virtual workshop, face-to-face session, or blended learning offer.
- Delivery can be configured as a short masterclass or a more in-depth applied programme depending on organisational need.

Tailoring and follow-up

Case studies and exercises can be tailored to local PSIRF priorities, action plans, and improvement challenges. Optional follow-up can include action review clinics, applied coaching, case-based learning, and support with embedding action design into governance and quality improvement processes. Participants receive a certificate of completion and are offered a 30-minute post-course support call.

5) PSIRF Investigation Masterclass

Advanced course for experienced staff leading complex investigations, thematic reviews, and higher-level learning responses.

Purpose: This advanced programme develops participants' capability to use Human Factors and systems-based investigation methods to lead high-quality patient safety investigations and learning responses in healthcare settings. It goes beyond introductory PSIRF training by equipping participants with a broader range of methods drawn from safety-critical industries and adapted for healthcare. The course strengthens capability not only in understanding how incidents happen, but also in designing stronger safety actions, supporting improvement, and contributing to safer system design. It is relevant to both reactive learning and proactive redesign of pathways, services, technologies, and work systems.

Why this course matters to organisations

This course is designed for organisations seeking to build deeper internal capability for complex investigations, learning response quality assurance, and thematic or cross-cutting learning. It supports competence and capacity under PSIRF, improves the quality of outputs, and strengthens the connection between investigation practice, governance, and measurable improvement.

Intended audience

Suitable for clinical and non-clinical staff who lead, support, commission, review, or oversee patient safety investigations and learning responses. Typical participants may include patient safety specialists, investigation leads, governance and risk leads, quality improvement leads, senior clinicians, matrons, service managers, divisional governance teams, educators, and digital or informatics leads involved in safety-critical system design. Participants are strongly recommended to have completed introductory patient safety and PSIRF learning beforehand.

Topics covered

- Safety-I, Safety-II, resilience, and the systems approach to patient safety
- SEIPS and socio-technical systems thinking
- Human Factors in service design, technology, and care delivery
- Safety-critical, hierarchical, cognitive, and applied task analysis
- Human reliability, performance variability, and error mechanisms in context
- AcciMap and systems-based contributory factor analysis
- Thematic analysis for recurring risks, incident clusters, and wider safety themes
- Human-computer interaction and digital safety issues
- Compassionate engagement with patients, carers, families, and staff
- Psychological safety, just culture, reporting culture, civility, and speaking up
- After Action Reviews and structured reflective learning methods
- Swarm huddles and rapid multidisciplinary learning responses
- Hierarchy of controls and stronger versus weaker safety actions
- Action evaluation, implementation considerations, and unintended consequences
- Translating learning into improvement and safer system design
- Report quality and learning response quality assurance

Learning outcomes

By the end of the course, participants will be able to:

- Use advanced Human Factors and systems-based methods to lead or support high-quality investigations and learning responses
- Apply tools such as SEIPS, task analysis, thematic analysis, and systems mapping to understand how work as done and system conditions shape safety
- Distinguish between superficial recommendations and stronger safety actions
- Design investigation outputs that are more aligned with PSIRF principles and sustainable improvement
- Engage more effectively and compassionately with patients, families, carers, and staff
- Analyse patterns across incidents, complaints, risks, and service changes
- Produce clearer, higher-quality findings and support the quality assurance of reports
- Bridge investigation practice, Human Factors expertise, and quality improvement to enable practical change

Format and duration

Available as face-to-face, virtual, or blended learning. The standard offer is an intensive three-day masterclass, with the option to extend into a multi-session applied programme with workplace follow-up.

Tailoring and follow-up

Pre-course discovery can be used to tailor the programme around local PSIRF priorities, common safety themes, anonymised incidents, digital safety issues, or service redesign challenges. Optional follow-up can include report review, action plan review, applied coaching, and support for embedding learning into governance and improvement processes. Participants receive a certificate of completion and are offered a 30-minute post-course support call.

6) Compassionate Engagement with Patients, Families and Staff Following a Patient Safety Event or Complaint



Specialist course focused on communication, relational practice, and compassionate involvement after harm, distress, or concern. responses.

Purpose: This course supports staff to engage compassionately, confidently, and constructively with patients, families, carers, and staff following a patient safety event or complaint. It focuses on the relational aspects of learning response and safety practice, helping participants navigate difficult conversations, support psychological safety, respond with empathy, and involve people meaningfully in ways that are respectful, proportionate, and aligned with organisational values.

Why this course matters to organisations

Compassionate engagement is central to effective patient safety response, staff support, and public trust. This course helps organisations improve the quality of conversations after harm, strengthen involvement in learning responses, support restorative practice, and build confidence among staff managing emotionally challenging situations.

Intended audience

Suitable for clinical and non-clinical staff involved in patient safety, complaints, patient experience, governance, incident response, family liaison, and operational or clinical leadership roles. It is particularly helpful for those who need to meet with patients, families, carers, or staff after an incident or complaint.

Topics covered

- Principles of compassionate and restorative engagement
- Understanding emotional responses after harm, distress, or concern
- Supporting staff, patients, carers, and families in difficult conversations
- Involvement in learning responses and incident review processes
- Psychological safety, empathy, and relational communication
- Working with conflict, distress, and differing perspectives
- Maintaining clarity, honesty, and professionalism in communication
- Linking compassionate engagement with learning, trust, and improvement

Learning outcomes

By the end of the course, participants will be able to:

- Approach post-incident or post-complaint conversations with greater confidence and compassion
- Use practical communication strategies to support constructive dialogue
- Involve patients, families, carers, and staff more meaningfully in learning responses
- Recognise and respond more effectively to distress, emotion, and relational tension
- Support a culture of openness, learning, and psychological safety

Format and duration

Available as a half-day, full-day, or tailored in-house workshop, delivered face-to-face or online.

Tailoring and follow-up

The course can be tailored to incident response pathways, complaints processes, patient experience priorities, or local restorative practice initiatives. Optional follow-up can include facilitated reflective sessions, team coaching, or case-based debriefs.

7) Thematic Analysis for Patient Safety Learning



Specialist course for teams who need to identify patterns, recurring risks, and system themes across incidents, complaints, claims, and other safety intelligence.

Purpose: This course provides a practical introduction to thematic analysis for patient safety learning. It helps participants move beyond single-incident thinking to identify recurring themes, common contributory factors, and system-level patterns across multiple data sources. The emphasis is on turning dispersed intelligence into useful insight that can inform PSIRF planning, governance discussions, service redesign, and proactive improvement.

Why this course matters to organisations

Organisations increasingly need to draw insight from multiple sources of safety information rather than treating incidents in isolation. This course helps teams improve the quality of thematic reviews, support more strategic learning, identify cross-cutting risks, and strengthen how incident, complaint, and risk information informs improvement priorities.

Intended audience

Suitable for patient safety specialists, governance and risk teams, quality improvement leads, divisional governance staff, service managers, and others involved in reviewing or synthesising safety information across departments or services.

Topics covered

- What thematic analysis is and when to use it
- Moving from single-event learning to cross-cutting insight
- Working with incidents, complaints, risks, audits, and other data sources
- Identifying themes, subthemes, and recurring contributory factors
- Using structured approaches to coding and synthesis
- Distinguishing signal from noise
- Presenting thematic findings in ways that support decision-making
- Linking thematic learning to PSIRF, governance, and improvement priorities

Learning outcomes

By the end of the course, participants will be able to:

- Describe the purpose and value of thematic analysis in patient safety work
- Use a structured approach to identify patterns across multiple sources of information
- Develop clearer thematic findings that support organisational learning
- Translate themes into improvement priorities, action planning, and governance discussion
- Contribute to more strategic, proactive approaches to patient safety learning

Format and duration

Available as a one-day workshop or a tailored applied programme using anonymised local material where appropriate. Delivery can be face-to-face, online, or blended.

Tailoring and follow-up

The course can be tailored to local governance structures, incident themes, or improvement priorities. Optional follow-up can include support with live thematic reviews, coding frameworks, or facilitated interpretation sessions for safety teams.

8) PSIRF Oversight Training (Leadership)



Specialist oversight training for leaders responsible for PSIRF governance, commissioning incident responses, and enabling learning-focused practice.

Purpose: This session gives participants the skills and knowledge to provide effective oversight of PSIRF and create the conditions in which learning can flourish. It draws on governance expertise to help leaders understand what matters most, how to assure that responses are proportionate, and how to support teams to translate learning into meaningful improvement. The session focuses on practical decision-making, oversight behaviours, and the challenges leaders face when incidents, complaints, and expectations compete for attention.

Why this course matters to organisations

Effective oversight is a core requirement of PSIRF implementation. Leaders need confidence to commission the right type of response, ensure that learning methods are applied well, and provide assurance that actions are proportionate, fair, and focused on system improvement. This course supports stronger governance, better quality assurance of incident response, improved alignment between PSIRF practice and organisational priorities, and healthier learning culture across teams..

Intended audience

Designed for leaders and senior roles with responsibility for patient safety governance and oversight, including executive and non-executive directors, divisional directors, heads of patient safety, clinical governance leads, risk and quality leads, medical and nursing leaders, and operational managers who commission, review, or assure PSIRF incident responses.

Topics covered

- Introduction to PSIRF and key documents (PSIRP, PSII standards) and how they relate to the organisation
- How to oversee and manage incident responses: proportionate decision-making, governance routes, and quality assurance
- Just culture and restorative practice: leader behaviours, fairness, and psychological safety
- Communication with those affected: patients, families, carers, and other staff (including second victims)
- Commissioning PSII and planning responses: scoping questions, terms of reference, and selecting the right method
- Barriers and challenges to investigations and learning: common failure modes and how leaders can address them

Learning outcomes

By the end of the course, participants will be able to:

- Explain the purpose of PSIRF and the role of key documents in providing organisational clarity and consistency
- Commission and oversee proportionate incident responses, including PSII, with clearer scope and expectations
- Apply just culture and restorative principles to leader decision-making and oversight conversations
- Strengthen compassionate communication with those affected, including staff support considerations
- Identify common barriers that reduce investigation and learning quality and take practical steps to remove them
- Ask better oversight questions and use simple quality indicators to assure learning and action follow-through

Format and duration

- Duration: Half-day (3 hours) or full-day (6 hours), depending on depth and local needs
- Delivery: Face-to-face or live online, using case examples, facilitated discussion, and governance scenarios
- CPD: Equivalent to 3 or 6 CPD points (dependent on duration)

Tailoring and follow-up

The session can be tailored to the organisation's PSIRF Incident Response Plan (PSIRP), governance committees, and current challenges (for example, investigation backlogs, response quality variation, or recurring themes). Optional follow-up can include an oversight clinic for leaders, review of commissioning documentation, or a focused session on strengthening quality assurance and action tracking. Participants receive a certificate of completion and are offered a 30-minute post-session support call.

Trainer Profile

All programmes are delivered by a Chartered Ergonomist who lectures in Human Factors and Patient Safety at Teesside University. This combines academic credibility with practical application for healthcare settings, and action follow-through

Delivery Options

Courses can be delivered in a range of formats to suit organisational need:

- Face-to-face
- Live online
- Blended format
- Stand-alone workshops
- Organisational capability-building programmes

For in-house delivery, content can be adapted to local priorities, service contexts, governance arrangements, and safety themes. Tailoring may include anonymised incidents, report review, action plan review, or context-specific case studies.

Additional Support Services

To complement training delivery, additional support can be offered to help organisations embed learning into practice:

- Action review clinics
- Report review and quality assurance support
- Applied coaching for learning response leads
- Case-based learning sessions
- Support with linking PSIRF practice to governance and quality improvement
- Follow-up implementation sessions for teams or safety leads

Closing Statement

If you are seeking to strengthen local PSIRF capability, develop internal confidence in Human Factors and systems-based learning, or improve how learning is translated into stronger safety actions and sustainable improvement, these programmes can be commissioned individually or as part of a broader organisational development offer.

About Us

We specialise in applying human factors in healthcare to help providers deliver safe, effective, affordable, person-centred care, and demonstrate to regulators that services are safe and well-led. We support you to:

Design and implement services, pathways, processes and work systems that work for patients and staff.

Investigate and learn from incidents, complaints and success; strengthening learning without blame.

Strengthen governance and assurance so decision-making is clear, evidence-based and insight-driven.

Build capability through coaching, mentoring and practical tools that teams can use day to day.

Every project is led by Chartered Ergonomist/Human Factors experts and delivered to consistently high professional standards. We have 20+ years' investigation experience, including 13+ years focused on healthcare safety investigations. We help clinicians and leaders apply proven approaches from safety-critical industries to build high-performing, reliable organisations.

We also bring senior and executive governance experience from both NHS and independent healthcare. This means we can connect board assurance to the realities of frontline work, helping Boards apply the same design discipline to information, assurance and decision-making that safety-critical industries rely on.



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